CORRECTIONAL MEDICAL SERVICES
MENTAL HEALTH SERVICES
INMATE CONTACT LOG

INMATE'S NAME Fountain, Tony AIS # 152157 MONTH/YR 5/98

DATE	Significant Obsv.	Signature
5/13/98	OK	M.H. Counselor, PMD
5/20	"	"

[illegible] DATE=19880[illegible] SEX = M MOUNTAIN, TONY IN = 17

	L	F	K	HS	D	HY	PD	MF	PA	PT	SC	MA	SI
RAW:	3	6	11	14	22	16	24	26	12	28	28	25	27
T:	46	57	48	57	63	49	62	61	62	60	61	71	52

WELSH CODE: * 9'246587-10/3:=

I IS THE BEST GROUP, LEVEL IS MED

GROUP= I LEVEL= MED TYPE= (01)

THIS IS THE BEST ADJUSTED OF ALL THE INMATE GROUPS WITH FEWEST PROBLEMS IN INSTITUTIONAL ADJUSTMENT AND INTERPERSONAL RELATIONSHIPS WITH BOTH PEERS AND AUTHORITIES. CRIMINAL RECORDS ARE USUALLY LESS SERIOUS THAN THOSE OF OTHER INMATE GRUPS AND THERE IS LESS SIGNIFICANT DRUG ABUSE. MORE OF THESE INMATES HAVE USUALLY BEEN INCARCERATED FOR PROPERTY CRIMES. THEY ARE LEAST LIKELY TO RECEIVE DISCIPLINARY WRITE-UPS AND RECIDIVISM RATES ARE TYPICALLY LOW. THERE IS, HOWEVER, HIGH ENERGY LEVL AND THEY ARE APT TO BE IMPULSIVE.
TREAIMENT APPROACHES SHOULD SHOULD BE DESIGNED TO TAKE ADVANTAGE OF THE FACT THA THEY ARE THE MOST LIKELY GROUP TO SUCCEED IN COMMUNITY PLACEMENT OR RESTITUTION CENTER TYPE PLACEMENT WHERE SENTENCING DATA PERMIT. THEY RESPOND WELL TO EDUCATIONAL AND VOCATIONAL TRAINING PROGRAMS AIMED AT DEVELOPING LEGITIMATE AVENUES OF FINANCIAL SUPPORT. ALTHOUGH THERAPEUTIC INTERVENTION IS NOT USUALLY A HIGH PRIORITY, REALITY THERAPY CAN BE EFFECTIVE.

GROUP= E LEVEL= LOW TYPE= (02)

THIS IS ONE OF THE THREE BEST INMATE GROUPS IN ADJUSTMENT AND INTERPERSONAL RELATIONSHIPS WITH PEERS AND AUTHORITIES. THEY ARE THE LEAST AGGRESSIVE, LEAST DEVIANT, AND BEST CONTROLLED: HOWEVER, PLACEMENT IN THIS GROUP SHOULD BE CHECKED AGAINST OTHER AVAILABLE DATA SINCE THERE IS SOME TENDENCY TO BE DEFENSIVE AND TO GIVE RESPONSES THAT PLACE THEMSELVES IN THE BEST POSSIBLE LIGHT. ALTHOUGH INTELLIGENCE LEVEL MAY BE HIGHER THAN OTHER GROUPS THEY TEND TO BE UNDERACHIEVERS. RATE OF DISCIPLINARY INFRACTONS IS LOW. PERFORMANCE IN VOCATIONAL TRAINING OR EDUCATION PROGRAMS IS USUALLY BETTER THAN WORK PERFORMANCE RATINGS. RECIDIVISM RATE IS LOWER THAN ANY OTHER INMATE GROUP.
TREATMENT APPROACHES INCLUDE SEPARATION FROM MORE AGGRESSIVE GROUPS, AVAILABILITY OF EDUCATIONAL AND VOCATIONAL TRAINING PROGRAMS AND THERAPY DESIGNED TO PROMOTE SELF-INSIGHT. THEY DO WELL IN RESTITUTION PROGRAMS WHERE SENTENCING DATA PERMIT AND CAN ALSO PROFIT FROM BRIEF INCARCERATION TO CALL ATTENTION TO THE SERIOUSNESS OF THEIR BEHAVIOR FOLLOWED BY SUPERVISED COMUNITY PLACEMENT.

MALE AGE 25 TH 8 19880127 FOUNTAIN, TO INST = 17

I T E M R E S P O N S E S

1 T	2 T	3 T	4 F	5 T	6 T	7 F	8 T	9 T	10 F
11 T	12 T	13 T	14 F	15 F	16 F	17 T	18 F	19 F	20 F
21 F	22 F	23 F	24 F	25 T	26 T	27 F	28 T	29 F	30 T
31 T	32 F	33 F	34 F	35 T	36 F	37 T	38 F	39 T	40 T
41 F	42 F	43 F	44 F	45 T	46 F	47 F	48 F	49 F	50 F
51 T	52 T	53 F	54 T	55 T	56 F	57 T	58 T	59 T	60 T
61 F	62 T	63 T	64 F	65 T	66 F	67 F	68 F	69 F	70 F
71 T	72 F	73 T	74 F	75 T	76 F	77 T	78 T	79 T	80 F
81 F	82 T	83 T	84 T	85 F	86 F	87 F	88 T	89 T	90 T
91 F	92 F	93 T	94 F	95 F	96 T	97 F	98 T	99 T	100 T
101 T	102 T	103 T	104 F	105 T	106 F	107 T	108 F	109 F	110 T
111 T	112 T	113 T	114 F	115 T	116 T	117 F	118 T	119 T	120 F
121 F	122 T	123 F	124 T	125 F	126 T	127 T	128 T	129 F	130 T
131 F	132 F	133 T	134 F	135 T	136 T	137 T	138 F	139 F	140 T
141 T	142 T	143 F	144 F	145 T	146 T	147 F	148 F	149 F	150 T
151 F	152 F	153 T	154 T	155 F	156 F	157 T	158 F	159 F	160 F
161 F	162 F	163 T	164 T	165 T	166 T	167 T	168 F	169 T	170 T
171 F	172 F	173 T	174 T	175 T	176 F	177 T	178 T	179 F	180 F
181 T	182 T	183 F	184 F	185 T	186 F	187 T	188 F	189 F	190 T
191 F	192 T	193 F	194 F	195 T	196 T	197 F	198 T	199 F	200 F
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421 T	422 F	423 F	424 F	425 T	426 T	427 T	428 T	429 T	430 T
431 F	432 T	433 F	434 T	435 T	436 T	437 T	438 T	439 T	440 F
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451 F	452 F	453 F	454 T	455 F	456 F	457 F	458 T	459 F	460 T
461 T	462 T	463 F	464 F	465 T	466 T	467 T	468 F	469 T	470 F
471 F	472 F	473 T	474 T	475 F	476 F	477 T	478 F	479 T	480 F
481 F	482 F	483 T	484 F	485 F	486 T	487 F	488 F	489 T	490 F
491 T	492 T	493 F	494 T	495 T	496 T	497 T	498 T	499 T	500 T
501 F	502 T	503 T	504 F	505 T	506 T	507 T	508 T	509 T	510 T
511 T	512 F	513 T	514 T	515 T	516 T	517 F	518 T	519 F	520 T
521 T	522 T	523 F	524 F	525 T	526 F	527 T	528 T	529 T	530 T
531 F	532 T	533 F	534 T	535 F	536 T	537 T	538 F	539 T	540 T
541 F	542 F	543 F	544 F	545 T	546 T	547 T	548 T	549 T	550 T
551 T	552 T	553 F	554 T	555 T	556 T	557 F	558 T	559 T	560 T
561 T	562 T	563 T	564 F	565 T	566 T				

C R I T I C A L I T E M S

THESE ITEMS WERE ANSWERED IN THE INDICATED DIRECTION. THOUGH TOO MUCH SIGNIFICANCE SHOULD NOT BE PLACED ON ANY INDIVIDUAL TEST RESPONSE, THESE RESPONSES MAY SUGGEST AREAS FOR FURTHER INVESTIGATION.

--- DISTRESS AND DEPRESSION ---

I AM EASILY AWAKENED BY NOISE. (T)
I CERTAINLY FEEL USELESS AT TIMES. (T)
MOST NIGHTS I GO TO SLEEP WITHOUT THOUGHTS OR IDEAS BOTHERING ME. (F)
I AM AFRAID OF LOSING MY MIND. (T)

--- IDEAS OF REFERENCE, PERSECUTION, AND DELUSIONS ---

IF PEOPLE HAD NOT HAD IT IN FOR ME I WOULD HAVE BEEN MUCH MORE SUCCESSFUL. (T)
SOMEONE HAS IT IN FOR ME. (T)
I HAVE NO ENEMIES WHO REALLY WISH TO HARM ME. (F)

--- PECULIAR EXPERIENCES AND HALLUCINATIONS ---

PECULIAR ODORS COME TO ME AT TIMES. (T)
I HAVE STRANGE AND PECULIAR THOUGHTS. (T)

--- SEXUAL DIFFICULTIES ---

MY SEX LIFE IS SATISFACTORY. (F)

--- AUTHORITY PROBLEMS ---

I HAVE OFTEN HAD TO TAKE ORDERS FROM SOMEONE WHO DID NOT KNOW AS MUCH AS I DID. (T)
IN SCHOOL I WAS SOMETIMES SENT TO THE PRINCIPAL FOR CUTTING UP. (T)
I HAVE NEVER BEEN IN TROUBLE WITH THE LAW. (F)

PSYCHOLOGICAL INTERVIEW / DATA ENTRY FORM

Name: FOUNTAIN, TONY AIS #: 152157 R/S B/M

Date: 01 / 30 / 89 DOB: 08 / 24 / 64 AGE: 24

Beta II 73 WAIS ___/___/___ WRAT-RL 04.7 Last School Grade Completed 10

MMPI Welsh Code *.9'246587-10/3:- Megargee Type ITEM 01 : EASY 02

General Appearance

*** a. Neat and generally appropriate NO PSI

___ b. Poorly groomed

___ c. Flat or avoiding interaction

___ d. Sad or worried

___ e. Other

I. Interpersonal Functioning

___ a. Normal-good relationships likely

___ b. Withdrawn / apparent loner

___ c. Likely to ignore rights / needs

___ d. Lacks skill or confidence

___ e. Probably difficult to get along with

*Other (Specify) ___ 1. ___ 2. ___ 3. ___ 4. *** 5. ___ 6. (See Copy)

II. Personality

**** a. Healthy

___ b. Antisocial

___ c. Paranoid

___ d. Explosive

___ e. Dependent

___ f. Passive-Aggressive

Other (Specify): ___ 1. Schizoid ___ 2. Schizotypal ___ 3. Histrionic ___ 4. Narcissistic ___ 5. Borderline ___ 6. Avoidant ___ 7. Compulsive ___ 8. Atypical/mixed ___ 9. See Copy (Write in your wording)

III. Substance Abuse

___ a. Alcohol addiction / abuse history

___ b. Drug addiction / abuse history

N-259

White to Central Records File
Yellow to Institutional File
Pink to Hospital Records

Entered Terminal
Date 1/30/89 By

*See manual for selections and numbers for "other"

___ c. Current use ___

___ d. Current addiction ___

*Other ___1. ___2. ___3. ___4. *** 5. *** 6. ___7. ___8.
*** 9. (See Copy) HE ADMITTED TO THE USE OF BEER AND THE USE OF MARIJUANA "EVERY ONCE AND AWHILE."

IV. Emotional Status

___ a. No significant problems

___ b. Depressed ___

___ c. Anxious or stressful ___

___ d. Angry or resentful ___

___ e. Confusion or psychotic symptoms ___

___ f. Mood disturbances ___

KK g. Sexual maladjustment ~~HE IS NOW CONVICTED OF THE KIDNAPPING AND RAPE OF~~ AN APPROX.15 YEARS OLD FEMALE. " THEY SAID THAT I DROVE UP NEXT TO HER AND PULLED HER INTO THE CAR AND DROVE OFF WITH HER. THEY COULD NOT FIND NO PROO
___ h. Paranoid ideation ~~OR NOTHING. I DID NOT KIDNAP HER . I DID NOT TAKE IT.~~ SHE WENT WITH ME AND AGREED TO IT."

___ i. Sleep / appetite disorder ___

*Other ___1. ___2. ___3. ___4. ___5. ___6. ___7. ___8.
___ 9. (See Copy) ___

V. Mental Deficiency

___ a. Mild

___ b. Moderate

___ c. Severe

*** d. Borderline

___ e. Organic impairment suspected

___ f. Memory deficit

Remarks: ___

*See manual for selections and numbers for "*other"

Psychological Interview / Data Entry Form
Page Three

VI. Management Problems

___ a. Suicide potential — Ideation ___ Plans ___ History of attempts / gestures ___

___ b. Serious mental history (specify) ___

___ c. Impulsive / acting-out behaviors predicted ___

___ d. Authority conflict ___

___ e. Manipulative / untrustworthy ___

___ f. Easily victimized ___

___ g. Escape potential ___

___ h. Assaultiveness ___

*Other ___ 1. ___ 2. ___ 3. ___ 4. ___ 5. ___ 6. ___ 7. ___ 8. ___ 9.(See Copy)

VII. Educational Needs

___ a. ABE ___ b. Special Education ___ c. Trade School ___ d. Jr. College

VIII. Mental Health Needs

Date referred Month ___ Year ___

___ A. Refer to psychiatric service
___ B. Substance abuse counseling
___ D. Stress management
** ___ F. Reality therapy
___ H. Values clarification
___ C. Depression
*** ___ E. Sexual adjustment
___ G. Anger induced acting out
___ I. Self-concept enhancement
___ J. Healthy use of leisure
___ K. Personal Development

RECOMMENDATIONS / REMARKS: RECOMMEND TO CONSIDER FOR MED.09 AT D.C.C.

Signature

1/30/89
Date

*See manual (pages 23-25) for selections for "other" Give number and wording of selection.

Prison Health Services
Treatment Record

Treatment Ordered:

SNellen Visual Screen
8/20/06

Date	Date	Date	Date	Date	Date	Date
8/21						
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Comments:

Patient Name/Number	Allergies:	Housing Unit:
Fountain, Tony 152157	Mold	Staton

Treatment Continued:

BP ✓ 2x week x 4 weeks

Date	Date	Date	Date	Date	Date	Date
8/14	8/17	8/21	8/24	8/28	8/31	9/4
134/91	130/90	142/92	128/76	144/98	150/86	
MS						
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
9/7						
128/98						
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date

Comments:

Notify MD of ≥ 160/100

Patient Name/Number	Allergies:	Housing Unit:
Fountain, Tony	Motrin	Staton
	152157	

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 08/10/06

To: Staton

From: NCU

Inmate Name: Fontain, Tony **ID#:** 152157

The following action is recommended for medical reasons:

1. House in
2. Medical Isolation
3. Work restrictions
4. May have extra ______ until ______
5. Other

Comments:

Blood pressure checks 2x weekly (~~Mon and Wed~~ Error) x4 weeks (Tues/Thurs)

Date: 08/10/06 **MD Signature:** [signature] **Time:** 1050

Prison Health Services

REFUSAL OF TREATMENT FORM

Institution: Staton

Resident's Name: Tony Fountain ID# 152167

D.O.B. 8/26/02

I, _____ (Name of Inmate) have, this day, knowing that I have a condition requiring medical care as indicated below:

A. Refused medication.

___ B. Refused dental care.

___ C. Refused an outside medical appointment.

___ D. Refused laboratory services.

f/u labs Re-send 8/17/04

___ E. Refused X-Ray services.

___ F. Refused other diagnostic tests

___ G. Refused physical examination.

✓ H. Other (Please specify)

Reason For Refusal _____

Potential Consequences Explained _____

I acknowledge that I have been fully informed of and understand the above treatment recommendations and the risks involved in refusing them. I hereby release and agree to hold harmless the state, statutory authority, all correctional personnel, medical/health personnel from all responsibility and any ill effects which may result from this refusal and I shall personally assume responsibility for my welfare.

I have read this form and certify that I understand its contents.

Witness Signature

Witness Signature

Date

Patient Signature

Time

NOTE: A refusal by the resident to sign requires the signatures of at least one witness in addition to that of the medical staff member.

PRISON HEALTH SERVICES INCORPORATED

Informed Consent to Medical Services

Inmate's Name: Fountain, Tony 152157

Date of Birth: 8-26-63 Social Security No.: _____

Date: 3/21/06 Time: 1 20 A.M. P.M.

I hereby authorize Prison Health Service, Inc. and Dr. Pevsner (Print Physician's Name), his assistant(s) or designee(s) to treat me as is necessary in his judgement.

The procedure(s), Digital Rectal Exam (state in Layman's terms), necessary to treat my condition has been fully explained to me by Dr. _____ and I understand the nature of, and risks associated with, this procedure(s). Briefly stated, they are: (Benefits) _____

(Risks) _____

I am aware that the practice of the medical sciences is not exact and I acknowledge that no guarantees have been made to me as to the results of this procedure(s). Alternate treatment methods and their consequences as well as the risks of refusing the described treatment(s) (if applicable) have been fully explained to me.

152157
(Signature of Inmate)

(Witness)

(Signature & Title of Provider)

(Witness)

60104 (6/90)

Treatment Continued:

B/P √ 2x wk x 4 wks

Date	Date	Date	Date	Date	Date	Date
1/19	1/20	1/24	1/27	1/31	2/3	2/7
128/80	No Show	140/92		No Show	No Show	No Show
MS	C			PM	L	PM
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
2/10						
M/S						
LVP						
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date

Comments:

Patient Name/Number	Allergies:	Housing Unit:
Fountain, Tony	Motrin	SCC

Treatment Continued:

BIP 1 Qwk x 4 wks

Date	Date	Date	Date	Date	Date	Date
1/31	2/7	2/14	2/21			
No show	No show		No show			
PM	PM		PM			
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date

Comments:

Patient Name/Number	Allergies:	Housing Unit:
Fountain, Tony 152150	NKA	Staton

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Tanner, Tony

LAST **FIRST** **MI**

DATE OF BIRTH 8/24/62 **SS#** 423-92-6603

Housing Recommendations:

General Population ✓

Medical Observation Unit____

Lower Level/Lower Bunk____

Suicide Precautions____

Special Watch (15 Minute Checks)____

Isolation____

Initiate Universal Precautions____

Individual found to be:

Frail/Elderly____

Physically Handicapped____

Developmentally Disabled____

Drug/Alcohol Withdrawal____

Special Mental Health Needs____

Expressed Suicidal Ideation____

History of Seizures____

Other____

Specify____

Nurse [signature] Date 12-13-04

GLF 1005 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

Staton Correctional Facility:

Sick call is performed at 7:00 pm in the health care unit Monday through Friday. All completed sick call requests and grievances must be placed in the locked sick call request box located beside the pill call window. All sick call requests must be completed and turned in by 2:30 pm daily.

Pill call is performed three times a day from the pill call room located in the common area at the times stated below. Pill call is subject to change by health care unit and security.

1. Morning pill call: 3:30 am
2. Noon pill call: 11:00 am
3. Evening pill call: 3:30 pm

Any dental, medical, or mental health educational information can be obtained through a written request to the Health Services Administrator.

I have had the opportunity to ask questions concerning the above information, and I have received a copy.

Tony Fountain

Inmate Signature: _____ Date: 12-13-04

Nurse Signature: _____ Date: 12-13-04

Access to Care
Prison Health Services
Alabama Department of Corrections

Incarcerated individuals are afforded timely access to care to meet their serious medical, dental and mental health needs in each health care unit.

In emergency situations you are to advise the nearest correctional officer for immediate health services activation.

Inmates in population areas may fill out a routine sick call request form and place the completed form in the sick call collection locked box conveniently located in your facility for daily medical collection and routing to the correct health division.

Population, weekend and holiday sick call written request are reviewed by nurse triage staff each day – weekends and holidays. Those identified as unable to medically wait for the next routine and scheduled nurse triage will be located for necessary assessment. Those found able to wait for the next regularly scheduled nurse triage encounter will be forwarded for review during normal operating hours.

Inmates in lock down or single cells (segregation) may give their sick call request daily to nursing service. You will be contacted within a 24 hour timeframe barring extenuating circumstances.

Incarcerated individuals are not punished for seeking care for their serious health needs.

You will not be denied access to care or care services by medical staff based on any inability to meet co-pay assessments. There is no charge for physicals as scheduled by medical staff, chronic care, medical initiated care, follow-up care (to include test results) or public health care needs.

Inmate health care encounters in each institution are set in accordance with institutional requirements as approved by the Warden.

Medical grievance forms concerning health services may be obtained in the same manner as sick call request forms and returned to health services in the same manner. In segregation you may also ask a correctional officer for a medical grievance form and return the completed form to the officer for forwarding to the unit Health Services Administrator for review. If you are unable to resolve the initial grievance submitted you will be issued a formal grievance for completion by the Health Services Administrator. This form is to be returned to the Health Services Administrator at your site. Grievances are reviewed within three days of receipt.

If you are eligible for our Keep on Person medication program you will be advised and offered the opportunity to participate.

Some over the counter medications are available to you in the canteen. Over the counter medications are not issued from health services as Keep on Person medication.

Medical staff is unable to release your health information to family members.

If you initiate a medical care encounter and are scheduled an appointment for medical or dental services, you are expected to keep your appointment or sign a release of liability form prior to the scheduled encounter. Medication is to be taken as ordered. If you miss your medication you are subject to a counsel by medical staff. Your medical care is important. This is a joint effort between the patient, department of corrections and Prison Health Services.

Your assigned institution will provide you a copy of pill call times, sick call times and other unit specific information you should be aware of.

HEALTH CARE UNIT

PATIENT INFORMATION SLIP

Bcc
INSTITUTION

FOUNTAIN, TONY
NAME

152157
NUMBER

B/M
R/S

Lay-in for _____ days from _____ to _____
(date)

_____ due to _____
(date)

Instructions: Bottom Bunk X 90 days

Failure to follow the directions above may result in a disciplinary.

6/29
Date issued

Signature

F-53

HEALTH CARE UNIT

PATIENT INFORMATION SLIP

SCC

INSTITUTION

Fountain Tony — **NAME**

152157 — **NUMBER**

Blm — **R/S**

Lay-in for _____ **days from** _____ **to**

(date)

_____ **due to** _____

(date)

Instructions: Discontinue bottom bunk profile.

Failure to follow the directions above may result in a disciplinary.

6/16/99 — **Date Issued**

Dr. Layburn/LPN — **Signature**

F-53

PATIENT INFORMATION SLIP

BCCF

INSTITUTION

Fountain Tony — NAME

152157 — NUMBER

B/n — R/S

Lay-in for ____ days from ____ to ____ (date)

____ due to ____ (date)

No lifting, no prolonged Standing
No bending until I Seen by
MD on Monday May 27, 199

Instructions: Sign up for sick
Call & Report to Sick Call
Screening on Sunday

Failure to follow the directions above may result in a disciplinary.

4-25-98 — Date Issued

Signature

F-53

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

Staton
INSTITUTION

Fountain Tony NAME 152157 NUMBER B R/S

Lay-in for ____ days from _____ to _____
(date) (date)

due to _____

Instructions: Bottom Bunk profile X 180 days

Failure to follow the directions above may result in a disciplinary.

5-14-01 Date Issued

R Mayo RN Signature

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

SCC
INSTITUTION

Fountain, Tony
NAME

152157
NUMBER

R/S

Lay-In for _____ days from _____ to _____
(date)

_____ due to _____
(date)

Instructions: Bottom Bunk x 6 mos.
10/6/00 - 4/6/01

Failure to follow the directions above may result in a disciplinary.

10/6/00
Date Issued

D. Morton/A. Lnlgs
Signature

F-53

HEALTH CARE UNIT

PATIENT INFORMATION SLIP

Staton

INSTITUTION

Fountain, Tony — **NAME**

152157 — **NUMBER**

B/m — **R/S**

Lay-In for _____ **days from** _____ **to**

(date)

_____ **due to** _____

(date)

Bottom bunk profile x

180 days

4/6/00 – 10/6/00

Instructions:

Failure to follow the directions above may result in a disciplinary.

4/6/00 — **Date Issued**

Dr Warren/Bennett — **Signature**

F-53

PATIENT INFORMATION SLIP

ECF

INSTITUTION

FOUNTAIN, TONY NAME

152157 NUMBER

B/M R/S

Lay-in for 2 days from 1-28-97 (date) to 1-30-97 (date) due to AN EXTRACTION.

Instructions: BED REST X 48 HRS.

Failure to follow the directions above may result in a disciplinary.

1-28-97 Date Issued

Signature

F-53

HEALTH CARE UNIT
PATIENT INFORMATION SL

Bullock
INSTITUTION

Fountain, Tony — NAME
152157 — NUMBER
B/M — R/S

Lay-in for ____ days from ____ to ____
(date)
____ due to ____
(date)

Instructions: Bottom Bunk Profile
x 6 months. Expires 7/14/99

Failure to follow the directions above may result in a disciplinary.

1/14/99 — Date Issued
C. Lewis RN — Signature

F-53

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Fountain, Tony
152157

D.O.B. 8/26/63
ALLERGIES:

Use Last Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain, Tony
152157

D.O.B. 8/26/63
ALLERGIES:

Use Fourth Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain, Tony
152157

D.O.B. 8/26/63
ALLERGIES:

Use Third Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain, Tony
152157

D.O.B. 8/26/63
ALLERGIES:

Use Second Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain, Tony
152157

D.O.B. 8/26/63
ALLERGIES:

Use First Date 10/6/06

DIAGNOSIS
- T4, TSH in 2 months
- D/C HCTZ hold Cozaar
- HCTZ 25 mg 1 PO QAM x 90 days
- Mevacor 20 mg 1 PO QPM x 90 days
- ✓ BP QD x 2 wks

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

RN

noted 10-6-06

60110 (4/03)

MEDICAL RECORDS COPY

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Fountain, Tony 152157 STATON D.O.B. 08/26/63 ALLERGIES: Motrin Use Last Date 09/29/06 1400	DIAGNOSIS (If Chg'd) note Check 9/30/06 0500 S1084 Profile I Fasting not checked if not done as ordered 8/18/06 HCTZ 25mg on hold until Bp/ Bp/ once daily x 14 days notify MD if ≥160/100 Hurricane 14-30 days re Bp/ ☐ GENERIC SUBSTITUTION IS NOT PERMITTED [signature]
NAME: Fountain, Tony 152157 D.O.B. 08/26/63 ALLERGIES: motrin Use Fourth Date 09/26/06 0840	DIAGNOSIS (If Chg'd) CBC 005009 (Lab unable to process 1st test) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED [signature]
NAME: Fountain, Tony 152157 FLYC D.O.B. 08/26/63 ALLERGIES: Use Third Date 8/28/06	DIAGNOSIS (If Chg'd) HCTZ 25 mg i PO QD x 30 days UM for Colonoscopy ☐ GENERIC SUBSTITUTION IS NOT PERMITTED [signature]
NAME: Fountain, Tony D.O.B. 8/26/63 ALLERGIES: Use Second Date 8/18/06	DIAGNOSIS (If Chg'd) 9-21-06 (1) Please sched colonoscopy - Hx Rectal bleeding (2) Comp panel, CBC, PT, 1XR/ASF) (3) Visual screen snellen ☐ GENERIC SUBSTITUTION IS NOT PERMITTED [signature]
NAME: Fountain, Tony 152157 STATON D.O.B. 08/26/63 ALLERGIES: motrin Use First Date 08/10/06 1100	DIAGNOSIS Notify MD if Bp ≥160/100 Hurricane 4-weeks re. Bp/ S04882A Profile II Fasting in 6 weeks Please take off order written 8/10/06 ☐ GENERIC SUBSTITUTION IS NOT PERMITTED [signature]

MEDICAL RECORDS COPY

60110 (4/03)

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Fontain, Tony (1)
152157
D.O.B. 08/26/63
Staton
ALLERGIES: Motrin
Use Last Date 08/10/06 1045

DIAGNOSIS (If Chg'd)
D/C mevacor
New mevacor 40mg po QHS x 1000 days
Annual Chest xray
Annual EKG
Bp 2x weekly x 4 weeks
☐ GENERIC SUBSTITUTION IS NOT PERMITTED
[signature] 8/11/06 1300
D Guicecraf

NAME: Fountain, Tony
152157
D.O.B. 08/26/63
ALLERGIES: Motrin
Staton
Use Fourth Date 08/02/06 0845

DIAGNOSIS (If Chg'd)
Please fax off site notes to Dr. McQueen w/ UM for colonoscopy
HCU visit to see Dr. Corbier 1-2 weeks re: Eval for colonoscopy need
☐ GENERIC SUBSTITUTION IS NOT PERMITTED
[signature]

NAME: Fountain, TONY
152157
D.O.B. 8/26/63
ALLERGIES: Motrin
Use Third Date 7/3/06

DIAGNOSIS (If Chg'd)
U M submitted for Colonoscopy evaluation
☐ GENERIC SUBSTITUTION IS NOT PERMITTED
[signature]

NAME: Fountain, TONY
152157
D.O.B. 8/26/63
ALLERGIES: Motrin
Use Second Date 6/6/06

DIAGNOSIS (If Chg'd)
(1) Mevacor 20mg po qd x 1000 days
(2) LFT's fasting 0?/?36 in 30 days & 90 days
[signature] 6/13/06
☐ GENERIC SUBSTITUTION IS NOT PERMITTED
[signature]

NAME: Fountain, Tony
152157
D.O.B. 8/26/63
ALLERGIES: Motrin
Date 4/21/06

DIAGNOSIS [illegible]
(1) HCU visit in 5 wk c̄ [illegible]
Please
(2) Profile & fasting in 30 days
[signature] 5/19/06
☐ GENERIC SUBSTITUTION IS NOT PERMITTED
[signature]

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: Fountain Jony
152157

D.O.B. 8/26/63
ALLERGIES: NKDA

Use Last Date 04/13/06 0924

DIAGNOSIS (If Chg'd)
Progress Order Hepatitis panel
ab ordered 3/07/06 + Rpt ordered
CD results in computer

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain Jony
152157

D.O.B. 8/26/63
ALLERGIES: Mother

Use Fourth Date 3/21/06

Noted 3-22-06 2 BLDW.

DIAGNOSIS (If Chg'd)
① 048827 testing on 4/3/06
② HCW visit 3-4 wks c
Rx Pergant

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain Jony
152157 STATON

D.O.B. 8/26/63
ALLERGIES: NKDA

Use Third Date 3/07/06 1700

DIAGNOSIS (If Chg'd)
Hep B #3 058560
Hep C 143991
noted 3/7/06

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain Jony
152157

D.O.B. 8/26/63 Staton 0810
ALLERGIES:

Use Second Date 2/22/06

DIAGNOSIS (If Chg'd)
HCW DRE re melena
048827 Before visit
2/22/06 1400

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain Jony
152157

D.O.B. 8/26/63 Staton
ALLERGIES:

First Date 2/08/06

DIAGNOSIS
EKG today

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME:

D.O.B. / /

ALLERGIES:

Use Last Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME:

D.O.B. / /

ALLERGIES:

Use Fourth Date / /

DIAGNOSIS (If Chg'd)

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain, Tony
152157 Stated

D.O.B. 8/24/62

ALLERGIES: NKDA

Use Third Date 9/28/04

DIAGNOSIS (If Chg'd)
HCU Visit Chest Pain
Appt 10/5 @ w
9/28/04

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain, Tony

D.O.B. / /

ALLERGIES:

noted allergies 6/29/04

Use Second Date 6/29/04

DIAGNOSIS (If Chg'd) ↑TSH
Thyroid panel 8/19/04

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Fountain, Tony
152157 Stated

D.O.B. 8/24/62

ALLERGIES: NKDA

noted Rammo 6/10/04 2:39 PM

Use First Date 6/10/04

DIAGNOSIS
HCU visit Chest Pain appt. 6/15 @
See Body Chart 69
CBC
CMP & Lipids
CXR PA Lat

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

60110 (4/03)

CORRECTIONAL MEDICAL SERVICES, Inc. **PHYSICIANS' ORDERS**

Name Jauntaus, Jonny D.O.B. 08.24.63

Location SCC ID# 152157 Allergies Motrin

Check box as order is noted:	(Date & Time)	
Noted by: A-Arnold	✓	Irrigate both ears
Date: 2/20/01		
Time: 1449		
M.D. Signature BF Daughtry MD	Date/Time 2/20/01 (0810)	
Check box as order is noted:	(Date & Time)	
Noted by:		
Date:		
Time:		
M.D. Signature	Date/Time	
Check box as order is noted:	(Date & Time)	
Noted by:		
Date:		
Time:		
M.D. Signature	Date/Time	
Check box as order is noted:	(Date & Time)	
Noted by:		
Date:		
Time:		
M.D. Signature	Date/Time	

PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Fountain, Tony 152157 D.O.B.: 8/26/63

3/21/06 20x/cp D.RE W+180

(S) 42 ½ yo BO → presented to SC c/o rectal bleeding off + on for 2 months × 1st SC & this was 2/20/06. Pt states the last blood passed was 2-3 days ago c spect of blood in stool. He reported to nursing staff that blood was on the toilet tissue. Pt. denies constipation or change in stool. He denies h/o ulcers, Hemorrhoids, and Anal fissures

(O) Abd NAD
Abdominal tenderness
NO inguinal hernias.
Rectal - NO Anal mucosal ∅ Hemorrhoids
NO fissures
Prostate 2+
specks of stool Hem ⊕

(A) - Rectal bleeding
- 2+ Prostate
- Abn LFT's ? Chronic Hepatic process
results / SGOT - 64
SGPT 119
- Elevated Lipids

FHX
⊕ Colon CA
⊕ Prostate CA

4/13/06 Labs reviewed 04-05-06 labs reported

138	103	10
4.5	—	1.0

ALT 58↑ Chol 249↑
AST 39 Trig 115
HDL 42
LDL 184↑

60111 (5/85) Complete Both Sides Before Using Another Sheet

Discussed

PHS
PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Fountain, Tony D.O.B.: / /
10/6/06	[illegible] f/u lab / ✓ [illegible] wt 183 T-97.4 P- 76
1250	R- 20 O2 sat 98% B/P 142/106 ——— [illegible]
	Pt. c/o Hematochezia 1st notice 2/2006 c̄ clots at times. Occasional dark at times but not melanotic. Occ. Abd pain.
	Labs
	Chem. profile Neg.
	Chol. → 177 HDL 44
	Trig 89 LDL -115
	TSH - 6.035
	~~CBC — WBC 5.8~~
	CBC 5.5 ⟩ 15.8 / 46.1 ⟨ 265
	A/P ① Hematochezia → Colonoscopy ordered. Pt. is Hemodynamically stable.
	② ↑ Bp / HTN → resume HCTZ
	③ Dyslipidemia → stable.
	[signature]

60111 (5/86)

Complete Both Sides Before Using Another Sheet

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Tony Fountain Date of Request: 6-12-06
ID # 152157 Date of Birth: 8-24-62 Location: E3-22
Nature of problem or request: Follow-up DR OR about 6-6-06, DR. person ordered me some medication to low my Bad Cholesterol level and told me to check the pill-Call window the following after-noon. I Checked the window 7/11 OF 1ST week Only to be told My Name was not in the Book

Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

no show
JL 6/18/06

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

54

Print Name: Tony Fountain
ID # 152157 Date of Birth: 8-24-62 Date of Request: 4-23-06
Location: E3-22

Nature of problem or request: On 2-20-06 I signed up to see doctor due to seeing Blood in My Stool. I have been taxed with Co-pay ment and has been Collected. Now I'm seeing inBlood of Spots I have notice Clots of Blood my Situation has WORSE. I was informed by the doctor to let you'll know. My symptom has gotten worse.

Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date: 4/24/06
Time: 7:00pm
Receiving Nurse Intials

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

S/C 4/25/06 ARBRN 9:24

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Tony Fountain
ID # 152157 Date of Birth: 8-24-62 Date of Request: 4-23-06 Location: E3-22

Nature of problem or request: On 2-20-06 I signed up to see doctor due to seeing Blood in My Stool. I have been given with Co-Pay ment and has been collected. Now I'm seeing instead of Stool I have notice Clots of Blood My Sizure also has worse. It was informed by the doctor to let you all know of my symptom had gotten worse.

Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date: 4/24/06
Time: 1:30pm
Receiving Nurse Initials: Drea

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PHS

Nursing Evaluation Tool: General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Fountain (Last) Tony (First) (MI)

Inmate Number: 152157

Date of Birth: 8 / 24 / 62 (MM / DD / YYYY)

Date of Report: 2 / 21 / 06 (MM / DD / YYYY)

Time Seen: _____ AM / PM Circle One

Subjective: Chief Complaint(s): I have blood on the tissue when using bathr

Onset: X several months

Brief History: Ø history of GI Bleeding
(Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 80 RR: 18 B/P: 130 / 90

Examination Findings: A+O - no c/o dizziness or weakness
(Continue on back if necessary) at ☐ blood seen in commode. More
Concern about Colon CA + having a Colonscopy
due to Age

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s): _____

☐ Referral NOT REQUIRED

☐ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens.

☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: _____ (Describe)

OTC Medications given ☐ NO ☐ YES (If Yes List): _____

Referral: ☐ NO ☐ YES (If Yes, Whom/Where): _____ Date for referral: __/__/__ (DD / YYYY)

Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (If emergent who was contacted?): _____ Time _____

x Helen Lightner RN
Nurses Signature

Name: Helen Lightner
Printed

2-22-06

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Tony Fountain Date of Request: 2-20-06
ID # 162157 Date of Birth: 8-24-62 Location: E3-22
Nature of problem or request: I'm occasionally noticing Blood in My Stool. On several occasions in the pass two months.

Signature

DO NOT WRITE BELOW THIS LINE

Date: 2/21/06
Time: _____ AM PM
Allergies: Motrin

RECEIVED
Date: 2/20/06
Time: 1000
Receiving Nurse Intials RS

(S)ubjective:

(O)bjective (V/S): T: 97.6 P: 80 R: 18 BP: 130/90 WT: 180

(A)ssessment: See work sheet

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PHS

Nursing Evaluation Tool: General Sick Call

Facility: BBB

Patient Name: Fountain Tony (Last / First / MI)

Inmate Number: 152157

Date of Birth: 8 / 24 / 62 (MM / DD / YYYY)

Date of Report: 10 / 31 / 05 (MM / DD / YYYY)

Time Seen: 1610 AM / PM Circle One

Subjective: Chief Complaint(s): Request eye exam

Onset: X 2 Months.

Brief History: (Continue on back if necessary) I need to see the Doctor about getting glasses. I have had a hard time reading X 2 months. I need alot & need to get glasses.

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.0 P: 78 RR: 18 B/P: 148 / 72

Examination Findings: (Continue on back if necessary) No chart available. Request to see eye Doctor for exam. No other complaints noted.

☐ Check Here if additional notes on back

Assessment: (Referral Status) Preliminary Determination(s):

☐ Referral NOT REQUIRED

☑ Referral REQUIRED due to the following: (Check all that apply)

☐ Recurrent Complaint (More than 2 visits for the same complaint)

☐ Other: glasses

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☑ Instructions to return if condition worsens.

☑ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☑ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)

☐ Other: (Describe)

OTC Medications given ☑ NO ☐ YES (If Yes List):

Referral: ☐ NO ☑ YES (If Yes, Whom/Where): Med for Review Date for referral: 10 / 31 / 05 (MM / DD / YYYY)

Referral Type: ☑ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): Time

X T. Smither (Nurses Signature) Name: T. Smither (Printed)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Tony Fountain Date of Request: 10/31/05
ID # 152157 Date of Birth: 08-24-62 Location: E-3-22
Nature of problem or request: I'm Requesting to see Eye Doctor Only. When Reading the words on pages Start Running Together.

Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment: SEE evaluation tool sheet

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PHS PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSTION DATE 3/8/05 TIME 4:15 AM (PM)

ORIGINATING FACILITY Staton ☐ SIR ☐ PDL ☐ ESCAPEE ☐

☐ SICK CALL ☐ EMERGENCY ☒ OUTPATIENT

ALLERGIES Motrin

CONDITION ON ADMISSION ☒ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

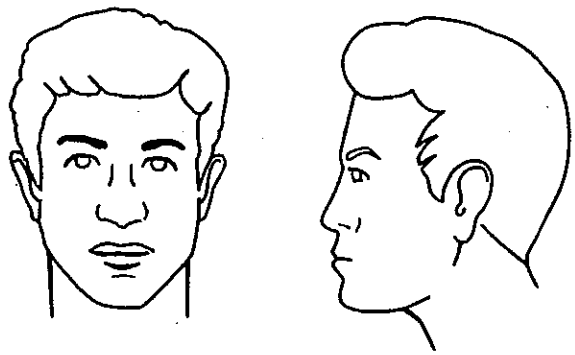
VITAL SIGNS: TEMP 97.5 (ORAL) RECTAL RESP. 20 PULSE 78 B/P 120/80 O2 Sat 99%

RECHECK IF SYSTOLIC <100> 50 /

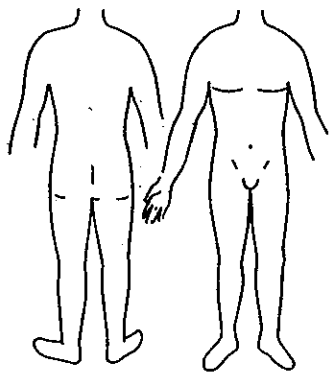
NATURE OF INJURY OR ILLNESS

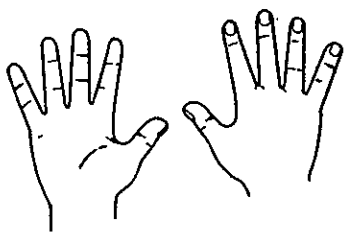
S) "I don't have any pains around my heart. Not they just comes & goes"

ABRASION ///	CONTUSION #	BURN XX XX	FRACTURE Z Z	LACERATION / SUTURES



PROFILE RIGHT OR LEFT





RIGHT OR LEFT

PHYSICAL EXAMINATION

O) NAD N - Denies any pains around heart @ this time
Ø s/s pain / discomfort noted
Ø facial grimmaces noted
EKG Summary: Borderline ECG

A) No alteration noted @ this time

P) EKG
MD, PA, CRNP to review

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY

DIAGNOSIS

INSTRUCTIONS TO PATIENT

If having any problems have shift officer call HCU

DISCHARGE DATE 3/8/05 TIME 5:20 AM (PM)

RELEASE / TRANSFERRED TO ☐ DOC ☒ AMBULENCE ☐

CONDITION ON DISCHARGE ☒ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE D Major, RN DATE 3/8/05

PHYSICIAN'S SIGNATURE [signature] DATE 3-9-05

CONSULTATION

INMATE NAME (LAST, FIRST, MIDDLE) Fountain, Tony

DOC# 152157 DOB 08/24/62 R/S B/M FAC. Staton

PHS-MD-70007 (White – Record Copy, Yellow – Pharmacy Copy)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Tony Fountain Date of Request: 10-24-04
ID # 152157 Date of Birth: 8-24-62 Location: E2-18
Nature of problem or request: I Requesting to see the Doctor for Chronic Chest pains that been happening Constantly. I was scheduled to see the doctor on 10-5-04, and was Forced to sign a waiver. By being lock in the cage from 7 until 12:20 p.m without being fed and water.

Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date: 10/26/04
Time:
Receiving Nurse Intials AHS

(S)ubjective:

10/25/04 NO sick call @ 2103 appearance.

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Tony Fountain Date of Request: 10-17-04
ID # 152157 Date of Birth: 8-24-62 Location: E 2-18
Nature of problem or request: Chronic Chest pains on the left-side of the upper part of my Chest. On October 5, 2004 a waiver was signed due to being locked in the cage from 7:00 until 12:20 p.m, without being fed. I like to Rescind My waiver of 10-5-04

Signature

DO NOT WRITE BELOW THIS LINE

Date: ___/___/___
Time: _____ AM PM
Allergies: _____

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

10/18/04 2045
No show for sick call

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

_____
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 6/9/04 TIME 750 AM/PM

ORIGINATING FACILITY STATON ☐ SIR ☐ PDL ☐ ESCAPEE ☐

☐ SICK CALL ☐ EMERGENCY ☒ OUTPATIENT

ALLERGIES NKDA

CONDITION ON ADMISSION ☒ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

VITAL SIGNS: TEMP 98.5 (ORAL) RECTAL RESP. 18 PULSE 114 B/P 130/90 RECHECK IF SYSTOLIC <100> 50 ___/___

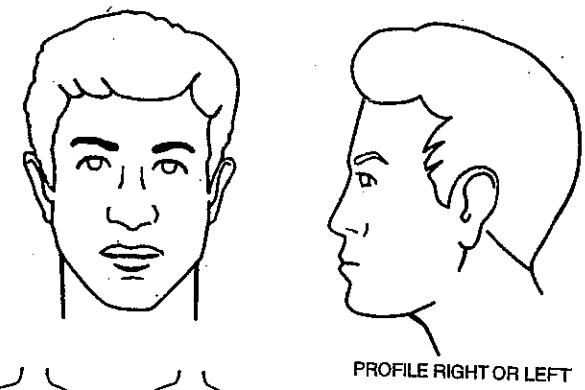
Ddat 972

NATURE OF INJURY OR ILLNESS

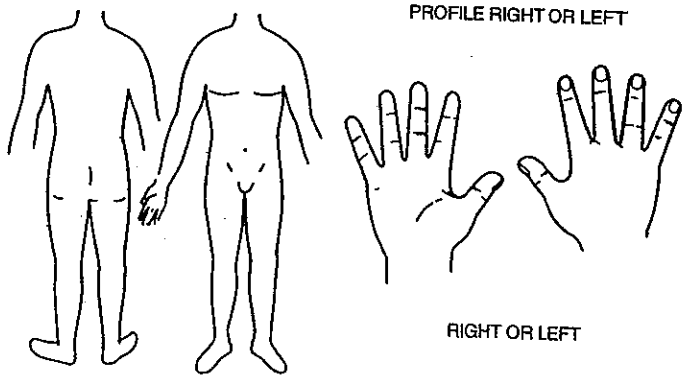
(S) C/O having chest pain with numbness to my L arm. I get dizzy, nauseated, short of breath.

MBarnett

ABRASION /// CONTUSION # BURN XX XX FRACTURE Z Z LACERATION / ___ SUTURES



PROFILE RIGHT OR LEFT



RIGHT OR LEFT

PHYSICAL EXAMINATION

(O) A&Ox3, resp reg & ease obsv WNL to touch. Pt c/o L side of chest has an aching, dull pain. Pt episode of C/P, ↓N+V @ this time. ↓numbness or tingling @ this time. ↓SOB- ↓dizziness/lightheadness @ this time. NAD @ this time

(A) Alteration in comfort

(P) MD/PA to Review

ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY
DEKG NOW		

DIAGNOSIS

INSTRUCTIONS TO PATIENT

Sick call PRN

HCU visit see orders

DISCHARGE DATE 6/9/04 TIME 805 AM/PM

RELEASE / TRANSFERRED TO ☐ DOC ☐ AMBULANCE ☐

CONDITION ON DISCHARGE ☐ SATISFACTORY ☐ FAIR ☐ POOR ☐ CRITICAL

NURSE'S SIGNATURE MBarnett DATE 6/9/04

PHYSICIAN'S SIGNATURE [signature] DATE 6/9/04

CONSULTATION

INMATE NAME (LAST, FIRST, MIDDLE) Fountain, Tony

DOC#	DOB	R/S	FAC.
152157	8-24-62	BM	STATON

PHS-MD-70007

(White – Record Copy, Yellow – Pharmacy Copy)

DEPARTMENT OF CORRECTIONS

TRANSFER & RECEIVING SCREENING FORM

ED: Inmate/Health Record

ion: KCF

: 11/23/04 Time: 1010 AM/PM

CEIVED FROM:

stitution/Work Release Center/Free-World Hospital

Staton

RECEIVING MEDICAL STATUS

- [x] Population
- [ ] Infirmary
- [ ] Isolation

RELEASED: Inmate/Health Record

Institution: Staton

Date: 11/22/03 Time: 2300 AM/PM

RELEASE FROM:

- [ ] Infirmary
- [ ] Segregation
- [x] Population
- [ ] Mental Health
- [ ] Other

RELEASE TO:

- [ ] DOC
- [ ] Infirmary
- [ ] Mental Health
- [ ] Kilby

Institution/Work Release Center/Free-World Hospital

ALLERGIES: Motrin

PHYSICAL EXAMINATION

Date of last exam: 10/15/03

Chest X-Ray Date: _____ Result: _____

PPD Reading 10/17/03 0mm

Classification: _____

Limitations: _____

LAB RESULTS - - LAST REPORT

	Date	Normal	Abnormal
CBC	11/3/98	[x]	[ ]
Urinalysis RPR	11/3/98	[x]	[ ]

	YES	NO
Wears Glasses/Contacts	[ ]	[ ]
Dental Prosthesis	[ ]	[ ]
Hearing Aide	[ ]	[ ]
Other Prosthesis	[ ]	[ ]

Recieving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

0

CURRENT MEDICATION - - DOSAGE AND FREQUENCY

0

MEDICATIONS	[ ] Sent w / inmate	[x] Not sent w / inmate
X-RAY FILM	[ ] Sent w / inmate	[x] Not sent w / inmate
HEALTH RECORD	[x] Sent w / inmate	[ ] Not sent w / inmate

Released to: Kilby

Date: 11/22/04 Time: 2330 AM/PM

MEDICATIONS	[ ] Received	[ ] Not Received
X-RAY FILM	[ ] Received	[ ] Not Received
HEALTH RECORD	[ ] Received	[ ] Not Received
CHART REVIEWED	[ ] YES	[ ] NO

Received by: _____

Signature of Receiving Nurse

Date: _____ Time: _____ AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: 0 LAST CLINIC: 0

FOLLOW-UP CARE NEEDED

- [x] Medical
- [ ] Dental
- [ ] Mental Health

Date	Time	With Whom - - Location (Sending Nurse)	Date/Appt. Made w/Whom (Rec. Nurse)
PRN			

NURSING ASSESSMENT (SENDING NURSE) (Noted from health record documentation)

		Yes	No
HISTORY	Drug Use		✓
	Mental Illness		✓
	Suicide Attempt		✓
	Chronic Care		✓
STATUS	Special Diet		✓
	Appearance		✓

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE) (Noted from inmate assessment)

		Yes	No
SKIN	Open Sores		✓
	Lice		✓
	Edema Hand	✓	
	Warm & Dry	✓	
	Cool & Moist		✓
CONDITION	Alert	✓	
	Oriented	✓	
	Uncooperative		✓
	Depressed		✓

INTAKE

Sick Call Procedures Explained	✓
Height	6'1"
Weight	175
Blood Pressure	134/90
Temperature	97.5
Pulse Resp.	98/18
Other	

Signature of Nurse Completing Assessment (Sending Nurse)

11/22/04 Date

Signature of Intake Screening Nurse (Receiving Nurse)

11/23/04 Date

INMATE NAME (LAST, FIRST, MIDDLE) Fountain, Tony

DOC#	DOB	Race/Sex	FAC.
152157	8/24/63	BM	SCF

PHS-MD-70009

(White - Medical Jacket, Yellow - Transfer Coordinator)

PRISON HEALTH SERVICES, INCORPORATED

DEPARTMENT OF CORRECTIONS

TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record

Institution: Elmore

Date: 12/5/04 Time: 1205 AM/PM

RECEIVED FROM:

Institution/Work Release Center/Free-World Hospital

Kilby

RECEIVING MEDICAL STATUS

- [x] Population
- [ ] Infirmary
- [ ] Isolation

RELEASED: Inmate/Health Record

Institution: KCF

Date: 12/5/04 Time: _____ AM/PM

RELEASE FROM:

- [ ] Infirmary
- [ ] Segregation
- [x] Population
- [ ] Mental Health
- [ ] Other _____

RELEASE TO:

- [x] DOC
- [ ] Infirmary
- [ ] Mental Health
- [ ] _____

Institution/Work Release Center/Free-World Hospital

ALLERGIES:

Unknown

PHYSICAL EXAMINATION

Date of last exam: 10/8/00

Chest X-Ray Date: _____ Results: WNL

PPD Reading 10/10/00 -

Classification: _____

Limitations: _____

LAB RESULTS - - LAST REPORT

	Date	Normal	Abnormal
CBC		[ ]	[ ]
Urinalysis		[ ]	[ ]
		[ ]	[ ]

	YES	NO
Wears Glasses/Contacts	[ ]	[x]
Dental Prosthesis	[ ]	[x]
Hearing Aide	[ ]	[x]
Other Prosthesis	[ ]	[x]

Recieving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

CURRENT MEDICATION - - DOSAGE AND FREQUENCY

Ø

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: _____ LAST CLINIC: 6

MEDICATIONS	[ ] Sent w / inmate	[x] Not sent w / inmate
X-RAY FILM	[ ] Sent w / inmate	[ ] Not sent w / inmate
HEALTH RECORD	[ ] Sent w / inmate	[ ] Not sent w / inmate

Released to: _____

Date: _____ Time: _____ AM/PM

MEDICATIONS	[ ] Received	[x] Not Received
X-RAY FILM	[ ] Received	[x] Not Received
HEALTH RECORD	[x] Received	[ ] Not Received
CHART REVIEWED	[x] YES	[ ] NO

Received by: Elmore RN

Signature of Receiving Nurse

Date: 12/13/04 Time: 1 - AM/PM

FOLLOW-UP CARE NEEDED

- [x] Medical
- [ ] Dental
- [ ] Mental Health

QRN

Date	Time	With Whom - - Location (Sending Nurse)	Date/Appt. Made w/Whom (Rec. Nurse)

NURSING ASSESSMENT (SENDING NURSE) (Noted from health record documentation)

		Yes	No
HISTORY	Drug Use		✓
	Mental Illness		✓
	Suicide Attempt		✓
	Chronic Care		✓
STATUS	Special Diet		✓
	Appearance		✓

OTHER PERTINENT NURSING ASSESSMENT

_____

NURSING ASSESSMENT (RECEIVING NURSE) (Noted from inmate assessment)

		Yes	No
SKIN	Open Sores		✓
	Lice		✓
	Edema		✓
	Warm & Dry	✓	
	Cool & Moist		✓
CONDITION	Alert	✓	
	Oriented	✓	
	Uncooperative		✓
	Depressed		✓

INTAKE

Sick Call Procedures Explained	✓
Height	6' 1"
Weight	161
Blood Pressure	130/80
Temperature	97.1
Pulse Resp.	90/20
Other	

Signature of Nurse Completing Assessment (Sending Nurse)

12/5/04 Date

Signature of Intake Screening Nurse (Receiving Nurse)

12/13/04 Date

INMATE NAME (LAST, FIRST, MIDDLE)		DOC#	DOB	Race/Sex	FAC.
Fountain, Tony	VOL. IFI	152157	8/26/63	B/M	Kct

PHS-MD-70009

(White - Medical Jacket, Yellow - Transfer Coordinator)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Tony Fountain Date of Request: 9-27-04
ID # 152157 Date of Birth: 8-24-62 Location: E2-18
Nature of problem or request: I have been having pains in My Chest (upper left side), for several Months. I have been X-Ray and Blood tested for these pains. And I have yet to hear anything. I signed up to see you guys on 9-22-04 and have yet be called to the Health unit.

Signature

DO NOT WRITE BELOW THIS LINE

Date: 9/27/04
Time: 7:25 AM (PM)
Allergies: Methanol

RECEIVED
Date:
Time:
Receiving Nurse Intials _____

(S)ubjective: C/O Stabbing & sometimes burning" pain in chest x 2 Months.

(O)bjective (V/S): T: 97.4 P: 72 R: 20 BP: 120/88 WT: 160#
Points TE Epigastric area & LUQ Quad TBD Auscultated Bowel Sounds - normal bowel sounds, LCTA, HRR
& Show for Sick Call 9/22/04

(A)ssessment: LCT in Health Care Mgt.

(P)lan: Refer to MD, PA, CRNP.

Refer to: (MD/PA) Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE (✓) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE 9/27/04

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

NaphCare

HEALTH SERVICES REQUEST FORM

Print Name: Tony Fountain Date of Request: 9-8-03

ID#: 152157 Date of Birth: 08-24-62 Housing Location: E2-18

Nature of problem or request: Two Weeks I had a Cold, that when I Cough I Coughed up blood on several occasions. And thought it was the Result of the cold. On 9-6-03 Saturday Morning I woke and experience the taste of blood in My Mouth.

Tony Fountain 152157

Sign here for consent to be treated by health staff for the condition described

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

****

HEALTH CARE DOCUMENTATION

Subjective: Cold

9.9.03
S
Brown

Objective: BP 110/60 P 70 R 20 T 97.3 Wt 167 Lungs clear Mod productive cough Heart RRR pinkish Sputum on Coughing

Assessment: Health Maintence

Plan: MD to Review

Refer to: ___ PA/Physician ___ Mental Health ___ Dental

Signature: RN Smith Title: RN Date: 9/9/03 Time:

e Name / Health Services Request Form
No. 152157 Date of Birth 08-24-62 Date of Request 2-1-03
ature of problem or request On or about December 29, 2002, I received a
parcel denture plate, that appears to be wearing out/or
worn a tear on the left-side of denture in the far back

Sign here for consent to be treated by health staff for the condition described above.

FEB 2 2003 Place this slip in Medical Box or designated area

DO NOT WRITE BELOW THIS LINE

Health Care Documentation

Subjective: S/c got lower partial last of December ~~past~~ back portion of it has split it is not uncomfortable - He just wants to make sure it is not going to be a problem

Objective: BP____ P____ R____ T____ WT____

Assessment: make Sick apt.

Plan:

Refer to: PA/ Physician Mental Health Dental

Education:

Protocol used: (specify)

Signature [signature] Title DA Time____ Date 2-3-03

Health Services Request Form

Print Name Tony Fountain

ID No. 152157 Date of Birth 08-24-62 Date of Request 11-14-01

Housing Location E2-18

Nature of problem or request I'm Requesting a Renewal of My bottom be
profile, which Expired on today. My Request is just a simple
Following-up and/or based on upon a Chronic back problems
By the way I have been charged numerous time For simple Renewal o
a bottom bed profile.

Sign here for consent to be treated by health staff for the condition described above.

Place this slip in Medical Box or designated area
DO NOT WRITE BELOW THIS LINE

Health Care Documentation

Subjective Renewal Bottom Bed they took money from me
And did not put it back it is a follow up
And I don't have to pay

Objective BP 120/80 P 60 R 20 T 98.6 wt 165
Alert w/s unl C/O of tenderness & pain on palpation
Ambulatory 3 difficulty hostile attitude refused
to answer questions

Assessment Alteration in comfort

Plan MD to Review

Refer to ○ PA/Physician ○ Mental Health ○ Dental

Signature A H Smith Title Lpn Date 11/15/01

CORRECTIONAL MEDICAL SYSTEMS
HEALTH SERVICES REQUEST FORM

Print Name: Tony Fountain Date of Request: 05-13-01

ID #: 152157 Date of Birth: 08-24-62 Housing Location: E2-18

Nature of problem or request: I'm Requesting the Renewal of My Bottom bed profile, which expired on April 6, 2001, I was also taxed with cost on April 20, 2001 and its yet to Receive My profile. I'm also experiencing a some sores in my throat, might be swollen glands or sinus problems.

I consent to be treated by health staff for the condition described.

SIGNATURE

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

* *

HEALTH CARE DOCUMENTATION

Subjective: I need my bottom bunk profile renewed. I have had a sore throat x 2 days now. I have gargle with salt and water it has not help.

Objective: BP 140/90 P 72 R 20 T 97.5 Wt 169.

Alert & Oriented x 3. Throat clear - amber secretion. Requesting a bottom bunk profile. Redness noted to throat

Assessment: Swollen lymph node noted on tenderness. Non-productive cough lungs clear. WNL No distress

Plan:

MD to review

Refer to: ___ PA/Physician ___ Mental Health ___ Dental

M. Bell CMP 05/14/01 0845

Signature: _____ Title: CMA Date: 5/14/01 Time: _____

CORRECTIONAL MEDICAL SYSTEMS
HEALTH SERVICES REQUEST FORM

Print Name: Tony Fountain Date of Request: 4-5-01

ID #: 152157 Date of Birth: 08-24-62 Housing Location: E2-18

Nature of problem or request: Renewal of My Bottom Bed Profile, I have a Chronic Back problems (injury), that places limits on Movements. My Bottom Bed Profile Expires on 4-6-01. (I have a Chronic Back injury.

I consent to be treated by health staff for the condition described.

SIGNATURE

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

HEALTH CARE DOCUMENTATION

Subjective: Bottom Bunk Profile Renewal

Objective: BP 120/80 P 70 R 20 T 98 wt 168 Alert skin warm et dry resp e/a limited ROM muscle spasms noted degenerative disc disease

Assessment: Alteration in Comfort

Plan: MD to Review

BPT 4-6-01 0930

AH Smith Jr 4/6/01 1120

Refer to: PA/Physician ___ Mental Health ___ Dental